PRINTED: 09/23/2011 FORM APPROVED OMB NO. 0938-0391

l		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	08/31/2	
			B. WIN		ADDRESS STEV STATE STR. COPE	00/31/2	.011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE		
KEYSTO	NE WOODS			1	RSON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
R0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)		DATE
KUUUU							
	This visit was for	r the Post Survey Revisit	R	0000			
		(PSR) to the Investigation of complaint					
	, ,	npleted on July 15, 2011.					
	Complaint IN000	093520 - not corrected.					
	Survey date: Au	oust 31 2011					
	Burvey date. Tru	gust 31, 2011					
	Facility number: 010409						
	Provider number	: 010409					
	AIM number: N	/A					
	Survey team:						
	DeAnn Mankell,	R.N.					
	Census bed type:						
	Residential: 55						
	Total: 55						
	10101. 33						
	Census payor typ	oe:					
	Other: 55						
	Total: 55						
	Sample: 6						
	Those state marid	antial findings are aited					
		ential findings are cited th 410 IAC 16.2-5.					
	in accordance Wi	ui 410 IAC 10.2-3.					
	Quality review 9	/07/11 by Suzanne					
	Williams, RN	,					
	·		1		ı		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

010409

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
			B. WIN	G		08/31/2	2011
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0052	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punish (5) neglect; and (6) involuntary see Based on record interview, the face cognitively impaindependently ar neglect and were that ensured they wandering and le without supervist affected 6 of 6 re with a dementiat had been asked the Agreement" white facility responsible leave the building including death (and F). Findings include 1. During the en 8/31/2011 at 10: Administrator proportion of the 1st screening too impairments. * = identifies as unal	chment; clusion. review, observation and cility failed to ensure direct residents, who were enbulatory, were free from example as a manner of were safe from eaving the building ion. This practice esidents in a sample of 6 diagnosis whose families to sign a "Negotiated Risk ch would not hold the oble if the resident would g and suffer injury (Residents A, B, C, D, E, dt.) d: trance conference on 15 A.M., the ovided a list of	RO	0052	Submission of the plan of corr does not constitute an admission of agreement by Keystone Wo Assisted Living Community walleged facts found on this sursubmission of this plan of corn is a matter of regulatory composite ACTIC WILL BE ACCOMPLISHED THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: The policy for utilizing Negotian Risk Agreements has been discontinued. The Negotiated Agreements for the residents identified in this survey have be discontinued. HOW THE FACILITY WILL IDENTIFY OTHER RESIDES HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTIC WILL BE TAKEN: The facility will no longer util Negotiated Risk Agreements.	on to ods with the vey. rection diance. DN(S) FOR D TO THE ated Risk DEED RISK TO BE DON	09/14/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2335 NORTH MADISON AVENUE KEYSTONE WOODS ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Negotiated Risk Agreements with their WHAT MEASURES WILL BE PUT family & physician to determine if they INTO PLACE OR WHAT will continue to reside in this setting." A SYSTEMIC CHANGES THE total of 16 residents had been identified as FACILITY WILL MAKE TO having cognitive impairments with 6 ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: residents identified as being unable to follow tasks and in the process of The policy for utilizing Negotiated obtaining a signed "Negotiated Risk Risk Agreements has been removed. Agreement." When a resident is assessed and we determine we are unable to meet their needs, the resident will be The administrator provided copies of the subject to the Notice of Discharge "Negotiated Risk Agreement" for process as outlined in the State Residents A, B, C, D, E, and F on Regulations. 8/31/2011 at 12:30 P.M. HOW THE CORRECTIVE ACTION(S) WILL BE A. Resident A and Resident B's guardians MONITORED TO ENSURE THE were sent a letter on August 16, 2011 with DEFICIENT PRACTICE WILL a copy of Resident A's and Resident B's NOT RECUR, I.E., WHAT Negotiated Risk Agreement. There were QUALITY ASSURANCE two different forms titled Negotiated Risk PROGRAM WILL BE PUT INTO **PLACE** Agreement. The letter stated "....The Negotiated Risk Agreement identifies the The Administrator will document in benefits and risks for Resident A and B to the Policy & Procedure Manual that continue to live at Keystone Woods we no longer utilize Negotiated Risk Assisted Living. Please review the Agreements. Negotiated Risk Agreement at your Completion Date: earliest convenience and then contact me September 14, 2011 to set up an appointment to discuss the outcomes of the Negotiated Risk Agreement." Resident A's "Negotiated Risk Agreement" had the following information:

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AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		NG	00	COMPL 08/31/2	ETED
		B. WING	TDEET	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			ORTH MADISON AVENUE		
KEYSTO	NE WOODS			SON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ΓAG	DEFICIENC1)		DATE
	"I/We are aware that Resident A has a risk					
	of cognitive impairments.					
	I/We are also aware that Keystone Woods					
	is an assisted living residence and is not a					
	residence designed to prevent cognitive					
	impairments and the resident may					
	experience the consequences of					
	elopement/wandering - unable to locate					
	facility, locked outside without being able					
	to summon for help, injury and death,					
	weather related injury.					
	As an assisted living residence where our					
	goal is to allow each person the rights of					
	dignity and autonomy, we will not force a					
	person to make decisions that are contrary					
	to what they want but may also not be in					
	their best interest. We therefore enter into					
	this agreement together. The staff at					
	Keystone Woods agree to the following					
	routine activities to lessen the risk: 1.					
	Entrance Doors are locked at 10 pm with					
	alarms activated from 10p (P.M.) -6a					
	(A.M.) to alert staff if the doors are					
	opened. 2. Surveillance Cameras on all 3					
	entrance doors. 3. 2-hour checks from					
	10p-6a on all 3 entrance doors. 4. 2-hour					
	checks on resident for whereabouts					
	confirmation. 5. call button response					
	system 6. After hours phone located next					
	to entrance door. 7. A sign posted on each					
	door directing one to use after hours					
	phone.					
	I/We are aware that Resident A could					
	experience the following consequence(s):					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QJSY12 Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	(X2) MULTIPLE CONSTRUCTION A PUBLICATION OO			(X3) DATE SURVEY COMPLETED	
ANDILAN	VOI CORRECTION	DENTIFICATION NOVIDER.	A. BUII			08/31/2	
			B. WIN		DDDEGG CITY CTATE ZID CODE	00/01/2	011
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE		
KEYSTO	ONE WOODS				SON, IN46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	injury including						
	This is an acceptable risk I/we are willing						
	1 ^	er to experience a higher					
		of life. I/we agree that the					
		ot be held responsible for					
	1	es of my decision." This					
	form was not sig	gned.					
	Resident B's Ne	gotiated Risk Assessment					
	had the same information except it had						
		ne on it. Resident B's					
	form was signed by the Administrator on						
	1	Director of Nurses on					
	8/30/11.	virgetor of rearses on					
	0/30/11.						
	Resident A's gua	ardians were mailed an					
	1	e "Negotiated Risk					
	Agreement" whi	•					
		uardian acknowledges					
		es to allow the Resident					
		g in the Community and					
		Resident suffers from					
		sion, and had been					
	1	lopement risk. The					
		stands this Resident					
		ependent and leave the					
		walks and sitting out of					
	1	take him/her into					
		vays and be put in harm's					
	way.						
	1 -	n understands that					
	1 ` ′	ident spent most of the					
	1	r apartment because the					
	1 -	able to get back into the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2011		
	PROVIDER OR SUPPLIER	<u> </u>	STREET A 2335 N	ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	locked for the ever lack of cognitive abilities, confusion unknown factors (c) The Guardian Negotiated Risk understand the Relive in the Community of taking numerous spouse has both including possibin spite of the far from cognitive delopement risk. (d) The Guardian Community discontinuity discontinuity discontinuity of the Community of the Com	Agreement because they desident's continuing to munity and forgetting how the Community as well as a walks with his/her benefits and risks, le injuries and death even at the Resident suffers efficits and is an an an, Resident and the sussed the following sof continuing to live in and the physician has alion as to continuing to munity. Somewhat is an				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
			B. WINC			08/31/2	011
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	-	
L/EV/OTO	NE WOODS				ORTH MADISON AVENUE		
KEYSIC	NE WOODS			ANDER	RSON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAU	+		+	IAU			DATE
	_	ers or an acute health					
	problem or dangerous traffic. (e) The following alternatives were						
	' '	_					
	presented to the	Resident by the					
	Community.	1					
		lant walk with him/her at					
	an additional co						
		phone that is able to be					
	used						
	- Immediately having a physical and						
	mental evaluation to determine whether						
	1	he Community alone will					
		ent to be at risk of loss of					
	life or other inju	-					
	_	the Community.					
	- Getting addition	onal memory care services.					
	(f) The Resident	t shall do the following to					
	allow him or her	r to continue living in the					
	Community.						
	1. To continue l	living in the Community					
	the Resident sha	all have a physical and					
	mental examina	tion to determine whether					
	they can safely l	leave the Community for					
	walks AND hav	e the cognitive ability to					
	use a cell phone	····					
	2. The Resident	and his/her spouse shall					
	each carry a cell	phone when leaving the					
	Community if th	ne physician deems they					
	can use it.						
	3. The Resident	and his/her spouse will					
		king with each other					
		attendant with them if the					
	physician finds	that one of them cannot					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QJSY12 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	construction 00	ľ	(X3) DATE SURVEY COMPLETED		
			B. WING		- 08/31	/2011	
	PROVIDER OR SUPPLIEF	2	2335	T ADDRESS, CITY, STATE, ZIP CO NORTH MADISON AVEN ERSON, IN46011			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	walk without an	attendant					
	4. The Resident	will move out of the					
	Community if the psychiatrist or primary						
	physician determ	nines that the Resident					
	cannot continue	to live in the Community.					
	(g) In addition, t	he Guardian on behalf of					
	the Resident will	I have and accepts total					
	responsibility for	r any resulting negative					
	outcome, includi	ing death because of					
	remaining in the	Community and doing as					
	stated in section	(f) above. The Resident's					
	family will be re	sponsible to monitor and					
	report to the Cor	nmunity any situation the					
	Resident or spou	se experiences when the					
	Resident is with	the family In addition,					
	the family will a	ttempt to accompany the					
	Resident and his	/her spouse whenever					
	possible out of d	oors.					
	2. RELEASE O INDEMNIFICA	F LIABILITY AND TION					
	Guardian hereby	agrees and instructs the					
	spouse, legal rep	resentative, power of					
	attorneys, estate,	and heirs of the Resident					
	to release, indem	nnify, and hold harmless					
	the Community	and its affiliates,					
	directors, officer	rs, employees,					
		attorneys, and agents					
	from any and all	costs, expenses,					
	· ·	s, losses, fines, penalties,					
	or other liabilitie	_					
	"Liabilities") ari:	` •					
	· · · · · · · · · · · · · · · · · · ·	the subject matter of this					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	08/31/2	
			B. WIN			00/31/2	011
NAME OF !	PROVIDER OR SUPPLIER				DRTH MADISON AVENUE		
KEYSTC	NE WOODS			l	SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I	·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	Agreement. Gua	ordian agrees that any					
	renegotiation or	termination of this					
	Agreement shall not render the release						
	and indemnify p	rovided about ineffective					
	as to any liability	incurred by the					
	Community now	or in the future arising					
		ection with the subject					
	1	reement. Guardian					
		release of liability and					
	1	begin on the date signed					
	below and continue until the end of time,						
		to its terms as stated					
	herein.						
	1	RESIDENT'S SPOUSE					
	AND FAMILY,						
		IVE ACKNOWLEDGES					
		AS READ OR HAD THE					
		TO READ THIS					
		THOSE SIGNING					
		OWLEDGE THAT					
		VOLUNTARILY					
	CONSENT TO A						
		TERMS AND HAD THE					
		TO DISCUSS THIS					
	AND LEGAL CO	SIDENT'S PHYSICIAN					
	AND LEGAL C	OUNSEL					
	This form was no	ot signed, nor were there					
	any names on the						
		. 101111.					
	Resident A's clin	ical record was reviewed					
	on 8/31/2011 at 1						
		gnoses included, but were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2011	
	PROVIDER OR SUPPLIER		2335 N	ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE SON, IN46011	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	not limited to, de	ementia and hypertension.			
	indicated a score scale for the querous points indicated dysfunction." Resident A's Carhave "2 hours ch (10p-6a)."	ompleted on 8/2/11 of "1.5 points." The stionnaire indicated 0-4 "severe brain e Plan indicated he would ecks for cognitive			
	Resident B's clinical record was reviewed on 8/31/2011 at 11:25 A.M. Resident B's diagnoses included, but were not limited to, dementia and osteoarthritis.				
	indicated a score scale for the que- points indicated dysfunction." Resident B's Car	ompleted on 8/2/11 of "1.0 points." The stionnaire indicated 0-4			
	interviewed on 9 The co-guardian pushed into a dec make." The faci all of my rights.	B's co-guardian was /1/2011 at 11:01 A.M. indicated "I feel like I'm cision I don't want to lity "wants me to waive They don't want to be ne co-guardian further			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	IPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	lG	00	COMPL	
			B. WING			08/31/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹	I		DDRESS, CITY, STATE, ZIP CODE		
KEVOTO	NIE WOODS				ORTH MADISON AVENUE		
	ONE WOODS		A	NDER	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES	II	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	17	AG	DEFICIENC!)		DATE
		nwyer had advised them					
	not to sign either of the forms and they						
	1	o sign the form, and the					
	co-guardians had talked and would not be						
	signing the form	S.					
	The Advisor						
	1	or was interviewed on					
		15 P.M. She indicated					
	1	Resident B had gotten the					
	second negotiated risk agreement because						
	1 ~	d a lawyer involved and it					
	1	dualized. She indicated					
		heir lawyer had the forms					
		Their doctor would need					
	1	to determine if they were					
	appropriate to re	emain in the facility.					
	1	clinical record was					
	reviewed on 8/3	1/2011 at 11:10 A.M.					
	Resident C's dia	gnoses included, but were					
	not limited to, de	ementia, congestive heart					
	failure, hyperten	sion, and degenerative					
	arthritis.						
	Resident C's "M	ental Status					
	Questionnaire" o	completed on 8/3/11					
	`	e of "3.5 points." The					
	1	stionnaire indicated 0-4					
	points indicated						
	dysfunction."						
	1 *	re Plan indicated she					
	1	ours checks for cognitive					
	(10p-6a)."						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPI	LETED	
			B. WIN			08/31/2	011
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE		
KEYSTO	NE WOODS			ANDER	SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	Resident C's "Ne	_					
	Agreement" had the following information:						
	"I/We are aware	that Resident C has a risk					
	of cognitive imp	airments.					
	I/We are also aw	are that Keystone Woods					
		ing residence and is not a					
		ed to prevent cognitive					
	1 ^	the resident may					
	experience the co	•					
	elopement/wandering - unable to locate						
	· -	outside without being able					
	weather related i	elp, injury and death,					
		ving residence where our					
		each person the rights of					
	-	nomy, we will not force a					
		lecisions that are contrary					
	_	nt but may also not be in					
	their best interes	t. We therefore enter into					
	this agreement to	ogether. The staff at					
	Keystone Woods	agree to the following					
	routine activities	to lessen the risk: 1.					
	Entrance Doors	are locked at 10 pm with					
		from 10p (P.M.) -6a					
	'	taff if the doors are					
	_	eillance Cameras on all 3					
		3. 2-hour checks from					
		entrance doors. 4. 2-hour					
		nt for whereabouts					
		call button response					
	l -	nours phone located next					
	to entrance door.	7. A sign posted on each					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 08/31/2011			
	PROVIDER OR SUPPLIER	<u> </u>	B. WING 00/31/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	phone. I/We are aware to experience the form injury including. This is an accept to accept in order level of quality or residence will not the consequence form was signed the Director of Normal During an interval Administrator or P.M., she indicated the Director of Normal During and interval During and i	r to experience a higher of life. I/we agree that the of be held responsible for s of my decision." This by the Administrator and Jurses. iew with the a 8/31/2011 at 12:14 ted the family of Resident agreement the week new were talking about the cheir doctors and will get said. "No one has signed clinical record was 1/2011 at 12:05 P.M. gnoses included, but were ementia, hypertension, ental Status completed on 8/3/11 to of "1.0 points." The stionnaire indicated 0-4						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	A. 1		A. BUIL	A. BUILDING 00 COMPLETE 08/31/2011			
			B. WING			06/31/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
VEVETONE WOODS					ORTH MADISON AVENUE		
KEYSTONE WOODS					SON, IN46011		(X5)
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN O			
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION) Resident D's Care Plan indicated she would have "2 hours checks for toileting/cognitive needs (10p-6a)."			IAG			DAIL
	toneting/cognitiv	e needs (10p-0a).					
	Resident D's "Ne	egotiated Risk					
	Agreement" had	•					
	information:	the following					
		that Resident D has a risk					
	of cognitive impa						
	1 ~ ^	are that Keystone Woods					
		ng residence and is not a					
		ed to prevent cognitive					
	impairments and	_					
	experience the co	_					
	_	ering - unable to locate					
	_	utside without being able					
	1	elp, injury and death,					
	weather related in						
		ving residence where our					
		each person the rights of					
	_	nomy, we will not force a					
	1	lecisions that are contrary					
	1 ^	t but may also not be in					
	1	t. We therefore enter into					
		gether. The staff at					
	ı ~	agree to the following					
	I -	to lessen the risk: 1.					
		are locked at 10 pm with					
		-					
		from 10p (P.M.) - 6a					
	· '	aff if the doors are					
	1 ^	eillance Cameras on all 3					
		3. 2-hour checks from					
	_	ntrance doors. 4. 2-hour					
	checks on resider	nt for whereabouts					

PRINTED: 09/23/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE: COMPL 08/31/2	ETED	
NAME OF PROVIDER OR SUPPLIER KEYSTONE WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	system 6. After It to entrance door, door directing or phone. I/We are aware the experience the form injury including. This is an accept to accept in order level of quality or residence will not the consequences form was signed the Director of North During an interval Administrator or P.M., she indicated D had gotten the before last and the agreement with the back to us. She still the sit yet." D. Resident E's reviewed on 8/31. Resident E's diagnot limited to, deatrial fibrillation.	able risk I/we are willing r to experience a higher of life. I/we agree that the of be held responsible for s of my decision." This by the Administrator and furses. liew with the a 8/31/2011 at 12:14 and the family of Resident agreement the week agreement the week are were talking about the heir doctors and will get said. "No one has signed clinical record was 1/2011 at 12:10 P.M. Ignoses included, but were ementia, hypertension, and history of stroke.						
	Questionnaire" c	ompleted on 8/2/11						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	A. î		A. BUII	A. BUILDING 00 COMPLETE 08/31/2011			
			B. WIN			06/31/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
KEVETONE WOODS				1	ORTH MADISON AVENUE RSON, IN46011		
KEYSTONE WOODS							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCE TO THE APPROFIDENCE)			
IAG	regulatory or LSC IDENTIFYING INFORMATION) indicated a score of "1.0 points." The		+	IAG			DATE
		stionnaire indicated 0-4					
	points indicated '						
	dysfunction."	severe orani					
	*	e Plan indicated he would					
		equests 2 hours checks					
	· ·	ight to ensure resident's					
	needs are met."	iight to ensure resident's					
	needs are met.						
	Dagidant Elg "Na	actional Diale					
	Resident E's "Ne	_					
	Agreement" had the following information: "I/We are aware that Resident E has a risk						
	of cognitive impa						
		are that Keystone Woods					
		ng residence and is not a					
	·	ed to prevent cognitive					
	impairments and						
	experience the co	-					
	_	ering - unable to locate					
		utside without being able					
		elp, injury and death,					
	weather related in						
		ving residence where our					
	_	ach person the rights of					
		nomy, we will not force a					
		ecisions that are contrary					
	l -	t but may also not be in					
		t. We therefore enter into					
	_	ogether. The staff at					
	l -	agree to the following					
		to lessen the risk: 1.					
		are locked at 10 pm with					
	alarms activated	from 10p (P.M.) - 6a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPL		
			B. WIN			08/31/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KEVOTO	WEVOTONE WOODO			1	ORTH MADISON AVENUE		
KEYSTONE WOODS				ANDER	RSON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG			-	IAG	DELICIENCE!		DATE
	· ′	aff if the doors are					
	1 ^	eillance Cameras on all 3					
		3. 2-hour checks from					
	_	ntrance doors. 4. 2-hour					
		nt for whereabouts					
		call button response					
	•	ours phone located next					
		7. A sign posted on each					
	· ·	e to use after hours					
	phone.						
		nat Resident A could					
	_	ollowing consequence(s):					
	injury including						
	_	able risk I/we are willing					
	_	r to experience a higher					
		f life. I/we agree that the					
		t be held responsible for					
		s of my decision." This					
	form was signed	by the Administrator and					
	the Director of N	urses.					
	During an intervi	iew with the					
		8/31/2011 at 12:14					
	P.M., she indicat	ed the family of Resident					
	E had gotten the	agreement the week					
	before last and th	ey were talking about the					
	agreement with t	heir doctors and will get					
	back to us. She s	said. "No one has signed					
	it yet."						
	E. Resident F wa	as observed walking					
	down the hallway	y. She said, "I'm trying					
	to make my way	home." When asked her					
	l	t answer. When asked					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY IPLETED /2011
			B. WING			72011
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP C IORTH MADISON AVEN		
KEYSTONE WOODS			ANDE	RSON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		was, she said, "I think				
	1	" She couldn't open the				
		vas walking down the				
	l -	d came around the corner				
		me of Resident F)."				
		'I can't find my room."				
		his is your room" and				
		om for the resident to				
	enter the room.					
	Resident F's clinical record was reviewed					
	on 8/31/2011 at	12:15 P.M.				
	Resident F's diag	gnoses included, but were				
	not limited to, de	ementia, hypertension,				
	macular degener	ration, and asthma.				
	Resident F's "Me	ental Status				
	Questionnaire" c	completed on 8/3/11				
		of "4.0 points." The				
		stionnaire indicated 0-4				
	points indicated	"severe brain				
	dysfunction."					
		e Plan indicated lacked a				
	notation of "2 h	ours checks for cognitive				
	needs (10p-6a)."					
	Resident F's "Ne	gotiated Risk Agreement"				
	had the following	g information:				
	"I/We are aware	that Resident F has a risk				
	of cognitive imp					
	I/We are also aw	are that Keystone Woods				
	is an assisted liv	ing residence and is not a				
	residence design	ed to prevent cognitive				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE :		
			B. WING			08/31/2	011
NAME OF PROVIDER OR SUPPLIER KEYSTONE WOODS			•	2335 NO	DDRESS, CITY, STATE, ZIP CODE DRTH MADISON AVENUE SON, IN46011	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	experience the conclusion elopement/wands facility, locked on to summon for his weather related in the As an assisted living goal is to allow edignity and autorises person to make of the weather best interest this agreement to the Keystone Woods routine activities. Entrance Doors a alarms activated (A.M.) to alert stopened. 2. Survey entrance doors. 10p-6a on all 3 echecks on residence confirmation. 5. system 6. After his opened. System 6. After his opened. I/We are aware the experience the foin injury including. This is an accept to accept in order level of quality of the summer and the confirmation.	ering - unable to locate utside without being able elp, injury and death, njury. Ving residence where our each person the rights of nomy, we will not force a decisions that are contrary that the three of the three enter into the enter					

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP - 08/31/2	LETED
	PROVIDER OR SUPPLIER		2335 N	ADDRESS, CITY, STATE, ZIP COE ORTH MADISON AVENUI SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	_	s of my decision." This by the Administrator and Jurses.				
	P.M., she indicate gotten the agreer and they were tall with their doctor. She said. "No of this deficiency was 2011. The facility of the said of the	iew with the a 8/31/2011 at 12:14 ted the families had ment the week before last lking about the agreement is and will get back to us. The has signed it yet." was cited on July 15, ty failed to implement a correction to prevent				